Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
Division of Health Professions Licensure

Board of Registration in Pharmacy
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COMMISSIONER

APPLICATION FOR DISABILITY ACCOMMODATION
PHARMACY LICENSING EXAMINATIONS

PART I: Applicant's Statement

Name_____ Social Security #_____
Address_____

Telephone Number ( )_____ Birthdate_____
Examination: NAPLEX_____ MPJE_____ State Exam_____ Test Dates_____
Description of disability and how it impacts taking examinations_____

Physician, Therapist, or Other Health Care Practitioner
(List additional practitioners on a separate sheet of paper and attach to this form).
Name_____
Office Address_____
Length of Time as Patient_____
Type of Accommodation Requested_____

If you have previously been provided with test accommodations, please list the provider and describe the accommodation(s)_____

Release

I authorize the practitioner(s) listed above to release to the Massachusetts Board of Pharmacy or its legal representative any and all information in his or her possession about my disability described above. "Information" means all information in the possession of or derived from providers of health care regarding my medical history, mental or physical condition, or treatment. I agree that this authorization shall be valid until cancelled in writing by me.

I understand that the Board of Pharmacy will use the information obtained by this authorization to determine eligibility for a reasonable accommodation with regard to the pharmacist licensure examination by reason of my disability. The Board reserves the right to require additional information or documentation to support this request for accommodation. The Board will not release any information obtained to any person or organization, except to NABP (the test developer), or any government agency that may be involved with my application to take the pharmacist licensure examination.

Under penalties of perjury, I declare that the foregoing statements and those in any accompanying documents or statement are true. I understand that false information may be cause for denial or loss of a license. I hereby certify that I personally completed this application and that I may be asked to verify the above information at any time.

Signature_____
Subscribed and sworn to before me this_____ day of_____ 20_____
Notary Public_____

Applicataion for Disability Accommodation
Pharmacy Licensing Examinations

Part II: Practitioner's Statement

Practitioner Name_____
Professional Title_____
Office Address_____

Telephone Number_____ State License Number (if applicable)_____
Patient's Name_____
Patient's Address_____

Patient's Social Security Number_____
Date Patient First Consulted_____ Date Patient Last Seen_____
Diagnosis of Disability and Basis for Diagnosis_____

Recommended Accommodation_____

Certification

I hereby certify that the above information is true and is provided pursuant to the authorization to release information by my patient. I also certify that I have the necessary specialized training to make the above diagnosis, that I personally examined the individual named above, and that the above diagnosis and assessment of accommodation request is my professional judgment. I understand that the Board of Pharmacy may contact me (with the applicant's permission) to obtain further information if necessary, and that the Board may obtain an independent assessment by another professional.

Practitioner's Signature_____ Date _____